

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030985

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 340 Primary Registration District No. 3075 Registrar's No. 63

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JUL 26 1963

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| 1. PLACE OF DEATH a. COUNTY <i>Stoddard</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Stoddard</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Dexter</i> | | c. CITY OR TOWN <i>Dexter</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>108 No. Nelson</i> | | d. STREET ADDRESS (If outside, give location) <i>205 West McCollum</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <i>Myrtle</i> Middle <i>May</i> Last <i>Frank</i> | | | 4. DATE OF DEATH Month <i>July</i> Day <i>21</i> Year <i>1963</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-7-1881</i> | 9. AGE (last birthday) <i>82</i> | IF UNDER 1 YEAR Months <i>6</i> Days <i>14</i> Hours <i></i> Min. <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired housekeeper</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <i>Stoddard County, Mo.</i> | |
| 12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i> | | 13a. FATHER'S NAME <i>Samuel Cooper</i> | | 13b. MOTHER'S MAIDEN NAME <i>Mary Anderson</i> | |
| 14. NAME OF HUSBAND OR WIFE <i>W. B. Frank (Deceased)</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | | 17. INFORMANT <i>Mabel E. Montgomery</i> | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema.</i> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>congestive myocardial failure.</i> | | |
| DUE TO (c) <i>old age</i> | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Debility and Incontinence</i> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <i>none</i> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>none</i> | |
| 20c. TIME OF INJURY Hour <i>none</i> a.m. <i></i> p.m. <i></i> Month, Day, Year <i></i> | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION <i>Dexter, Mo.</i> | |

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| 21. I attended the deceased from <i>9-5-62</i> to <i>7-21-63</i> and last saw her alive on <i>7-21-63</i> . Death occurred at <i>7-21-63</i> <i>2:00</i> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE OF PHYSICIAN <i>Lewis C. Jones, M.D.</i> | 22b. ADDRESS <i>Northington Clinic Dexter, Mo.</i> |
| 22c. DATE SIGNED <i>7-22-63</i> | |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>7-23-63</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Harper</i> | 23d. LOCATION (City, town, or county) (State) <i>Near Aid, Missouri</i> |
| 24. FUNERAL DIRECTOR <i>Rainey Funeral Home,</i> | ADDRESS <i>Dexter, Mo.</i> | 25. DATE RECD. BY LOCAL REG. <i>7-22-63</i> | 26. REGISTRAR'S SIGNATURE <i>Walter J. Jones</i> |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Lucille Rainey

Licensed Embalmer No. 4983

P. O. Address Dexter, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.